Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Antidepressant Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Cymbalta, Effexor, Effexor XR, Lexapro, mirtazapine orally disintegrating tablet, Paxil CR, Pexeva, Prozac Weekly, Sarafem, Symbyax, Zoloft, Wellbutrin XL, and brand-name multiple-source antidepressants that have an FDA "A"-rated generic equivalent. Additional information about antidepressants can be found within the MassHealth Drug List at www.mass.gov/masshealth.

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m

Member's place of residence ☐ home ☐ nursing facility

Medication information

Antidepressant request

- ☐ Cymbalta
- ☐ Effexor
- ☐ Effexor XR
- ☐ Lexapro
- ☐ mirtazapine orally disintegrating tablet
- ☐ Paxil CR
- ☐ Prozac Weekly
- ☐ Symbyax
- ☐ Zoloft
- ☐ Wellbutrin XL
- ☐ Other _____
- ☐ Brand Name * _____

*Please attach supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA Medwatch form regarding adverse reaction or inadequate response to the generic product.)

Dose, frequency, and duration of requested drug

Drug NDC (if known)

Indication for antidepressant requested (Check all that apply.)

- ☐ Depression
- ☐ Obsessive-compulsive disorder
- ☐ Panic disorder
- ☐ Premenstrual dysphoric disorder
- ☐ Other (describe): _____

Please list all other psychotropic medications currently prescribed for the member.

Has member been hospitalized for this condition?

☐ Yes. Dates of most recent hospitalization _____ ☐ No

Is member under the care of a psychiatrist? ☐ Yes ☐ No

Name of psychiatrist _____ Telephone no. _____

Date of last visit or consult with psychiatrist_____

Medication information continued

For Lexapro or Zoloft, documentation of at least 2 generic SSRI trials is required.
For Cymbalta or Effexor, documentation of a trial of at least 1 SSRI and 1 other antidepressant (which may include another SSRI) is required.
Please complete Box A and B below to document past antidepressant trials.

For all other antidepressant requests (eg, orally disintegrating tablets, Paxil CR, Prozac Weekly, Wellbutrin XL, etc), please describe the medical necessity for the medication requested (attach letter with details if more space is needed)*:

A. SSRI name

Dates of use	Dose and frequency

Did member experience any of the following?

☐ Adverse reaction ☐ Inadequate response ☐ Intolerance ☐ Other

Briefly describe details of adverse reaction, inadequate response, intolerance, or other:

B. SSRI or other antidepressant name

Dates of use	Dose and frequency

Did member experience any of the following?

☐ Adverse reaction ☐ Inadequate response ☐ Intolerance ☐ Other

Briefly describe details of adverse reaction, inadequate response, intolerance, or other:

* Prescriber may be asked to provide supporting documentation (e.g., copies of medical records and/or office notes).

Pharmacy information

Name	Pharmacy provider no. *Optional*	Telephone no. ( )	Fax no. ( ) *Optional*	
Address		City	State	Zip *Optional*

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address *Optional*			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date